STATE OF MICHIGAN
DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES
OFFICE OF FINANCIAL AND INSURANCE SERVICES

A Report on Medicaid Timely Claims Payment
October 1, 2001

Background:

The state delivers health care treatment and services to its Medicaid recipients through a managed care system using qualified health plans (QHPs). These QHPs are health maintenance organizations that have bid, been selected, and entered into contractual arrangements with the state to provide Medicaid services in particular regions. The QHPs may establish contracts with health care providers and facilities to deliver Medicaid services in accordance with federal and state laws and policies. These contracts prescribe, among other things, the duties of both parties for the submission of claims and payment for health care treatment and services. Despite the contracts, medical care providers expressed some difficulty in obtaining timely payments from QHPs for the providers' Medicaid services. Both the Medicaid providers and QHPs suggested the state establish a regulatory structure to ensure the timely payment of claims, efficient claim submission and reimbursement procedures, dispute resolution, and penalties for failure to comply with timely payment requirements.

Legislation:

On June 20, 2000 Public Act No. 187 of 2000 (the Act) became effective. That legislation amended sections 111a and 111b of the Social Welfare Act, 1939 PA 280 (MCL 400.111a and 400.111b) and added section 111i (MCL 400.111i). The new section, in part, requires the Commissioner of the Office of Financial and Insurance Services (OFIS) to report on the timely claims process and payment procedure established under section 111i. This report by the Commissioner to the Legislature includes OFIS Bulletin 2000-09, issued on November 16, 2000, which clearly outlines the claims process to be used by providers and the payment procedures to be used by the QHPs to facilitate timely payment of claims as required by the Act. A copy of Bulletin 2000-09 is attached for your information.

Commissioner's Bulletin:

Bulletin 2000-09 also identified and established a reporting system and form (Medicaid Clean Claim Report, FIS 0278) for providers contracted with QHPs to report directly to the Commissioner clean claims that were not paid by the QHPs within 45 days. A copy of this reporting form is attached for your review but can also be easily accessed by a QHP or a Medicaid provider at the OFIS web site (www.cis.state.mi.us/ofis).

Bulletin 2000-09 included another form (Quarterly Notice of Medicaid Claims Defects, FIS 0279, copy attached) for QHPs to report directly to the Commissioner the number of Medicaid claims denied after a second submission and the reason for that second denial. The QHPs were required to file this report with the Commissioner by the end of the month following the reporting quarter for compliance with section 111i(2)(i). This report compiles the information sent to the Commissioner from the providers and the QHPs and fulfills section 111i directing the Commissioner to produce such a report.

Outcomes:

As of the date of this report very few Medicaid providers have made inquires to OFIS regarding use of the Medicaid Clean Claim Report, and no completed form has been submitted.

For the first quarter of calendar 2001, 5 of the 19 QHPs were unable to provide the information requested on the FIS 0279 form and were referred to the OFIS Code Enforcement Division for regulatory action. Each of these companies was assessed a $500 fine for failure to comply with the Commissioner's inquiry. These 5 QHPs reported that their data systems could not cross-reference claims to determine if a claim was an original filing of a claim or a second submission of a previously filed claim. QHPs are only supposed to report claims denied twice. The 5 QHPs, therefore, were unable to report the requested information despite a statutory requirement in place since June 2000.

Since the date enforcement action was taken, 4 of the 5 QHPs have paid their fine and did submit required information for the first quarter of 2001. One QHP is still having difficulty producing the necessary information and to date has not complied with this reporting requirement.

Among the elements on which QHPs must report are the numbers of claims that have been denied twice. One difficulty in making a like comparison among the plans was the inconsistency in the claims counting method. A claim form may include data on one service or several services. The individual services listed on a claim form are usually called "claim lines." Under the Act, a QHP must pay for services on a claim form that are legally payable, even if one or more services, or "claim lines," may not be payable. After receipt of the timely claims report from the QHPS, it was determined that some QHPs had counted the number of claim forms that had been denied twice; other QHPs had counted the number of "claim lines" that had been denied twice, even though more than one "claim line" may be on the same claim form.

OFIS intends to issue a clarification statement to the QHPs to have them report the number of denials on an individual "claim line" basis. This method will provide more accurate reporting and improve comparison of information and analysis.

Another difficulty encountered was the lack of summary data provided by some of the QHPs. In these cases staff had to manually count claims denials. OFIS's

clarification statement will include a requirement that a standardized summary report must be included in each quarterly report. The summary will assist OFIS in its analysis of the reported information.

Based on the information received from the reporting QHPs for the first two quarters of 2001, OFIS compiled a table for each quarter. The tables are attached for your information. OFIS made the following observations from the reported information:

- The most frequent reasons reported by the QHPs to deny a Medicaid claim for a second time include:
    - Claim submitted is duplicate claim for one the QHP has already paid or rejected
    - No authorization for the service is on file
    - Beneficiary was not eligible at the time of service
    - Claim was submitted more than 12 months from the date of service
- Each QHP has its own set of codes for denying claims and the number of denial codes can range from a dozen to 100 or more which makes comparing and analyzing claims information difficult
- The range of reported claims denied twice during a reported quarter range from 9 to 26,021.
- The range of reported claim lines denied twice during the first two quarters ranged from 130 to 24,065.
- The percent of claims denied twice of the total number of claims received by a QHP ranges from .37% to 8.7%.

From the information provided by the QHPs it was determined the rate of claims denial by one plan was far greater than any other QHP. OFIS is investigating this matter to determine what reasons there may be for the high denial rate.

The last year has been a learning experience for OFIS, the Medicaid providers, and the QHPs. As the QHPs' reporting abilities improve to allow them to report claims denials as required under the Act, it will become easier for OFIS to analyze the information submitted by the QHPs. This will enable OFIS to identify which QHPs have a higher proportion of twice denied Medicaid claims. OFIS anticipates the reporting of this information will assist QHPs and their health care providers to be better informed of specific circumstances that cause Medicaid claims to be denied twice. With this knowledge, both QHPs and providers will be better able to work collaboratively to resolve problems that cause claims to be denied.

Office of Financial and Insurance Services

Notice of Medicaid Claims Defects

Second Quarter 2001, April 1 - June 30

Source: HMO reported FIS 0279 (information is not audited)

No. of HMOs	Alphabetical Listing Name of HMO	Number of total claims processed	Number of claims denied twice	Percent of claims denied twice	Most common reason for claims denied second time	No. of Claims	Second most common reason for claims denied second time	No. of Claims	Third most common reason for claims denied second time	No. of Claims	Fourth most common reason for claims denied second time	No. of Claims	Fifth most common reason for claims denied second time	No. of Claims
1	Botsford*	NR	470	NA	Dup of previous rej claim	102	Not enrolled on date of service	68	No referral on file	55	Non-emergent	39	Require medical records	32
2	Cape Health Plan*	NR	2,300	NA	Dup claim prev paid	1,578	Service not payable resubmit w/author	132	Sevice not covered	116	Included in ER/office visit	94	Provider service covered under cotract	94
3	Care Choices	NR	1,881	NA	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP
4	Community Care Plan*	NR	93	NA	Member not eligible fo	17	Not a covered benefit	17	Duplicate-CLM-Mem not	16	Dup claim-pymt already	11	2 Digit POS code requi	10
5	Community Choice MI	NR	6,228	NA	NP	NP	NP	NO	NP	NP	NP	NP	NP	NP
6	Great Lakes Health Plan	203,412	2,866	1.41%	Serv was previouly paid	671	Please submit primary carrier EOB	332	Invalid/Missing/inap prop proc/units	296	Missing/invalid place of service	285	Hosp failed to obtain IP approval	207
7	Health Plan of MI	81,160	526	0.65%	Svs not auth/not responsible for Svs not auth	375	Invalid code 4th or 5th digit required	52	Procedure code is not covered by Medicaid	47	Resubmit with copy of primary insurance voucher	15	No. of services authorized has bee exceeded	8
8	Health Plus of MI*	NR	16,677	NA	No authorization, invalid for date	4,841	Member ineligible on date of service	2,928	Other coverage liable	1,855	Same proc prev paid	1,274	Diagnosis not reported or incorrect	996
9	M-CARE*	NR	130	NA	Info Duplicate of a denied claim	50	Full payment do not bill member for balance	44	Full payment less copay do not bill member for balance	16	Serv paid in a pre-paid cap arrange	8	Pended authorization required not found systematically	3
10	McLaren Health Plan	NR	8	NA	Charge previously considered	8	0	0	0	0	0	0	0	0
11	Midwest Health Plan	NR	904	NA	No authorization on file	222	Re-submit with copy of authorization	176	Emergency Dept. report required	94	Non-emergent Rebill as 99281	83	Capitated lab services	67
12	Molina	NR	39	NA	Member not enrolled on DOS	13	Requires authorized referral	6	Resubmit with primary EOB	5	Requires prior authorization	5	Claim submit time exceeded	3
13	OmniCare Health Plan	NR	0	NA	0	0	0	0	0	0	0	0	0	0
14	PHP of Mid-Michigan	54,617	1,156	2.12%	Requires notif/plan not notified	293	Duplicate	127	After member exp date	86	Duplicate-original claim still pending	83	Send primary carrier's EOB	56
15	PHP-SW	56,154	879	1.57%	Duplicate	142	Requires notif/plan not notified	131	Not eligible chg/don't bill patient	53	SVC included in primary proc	48	After member exp date	47
16	Priority Health Plan	74,909	290	0.39%	Claim duplicate of previous claim	290	NR	NR	NR	NR	NR	NR	NR	NR
17	Total Health Care*	255,012	130	0.05%	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP
18	UP Health Plan*	NR	1,712	NA	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP
19	The Wellness Plan	296,005	24,746	8.36%	Late claim submitted over 1 Yr. From DOS	10,438	Duplicate claim previously paid	6,183	Member not eligible at time of service	1,744	Non-emergent not medically necessary	1,064	Not authorized	1,064

*HMOs reporting claim lines

Cape; For second quarter claims limited to those with a DOS after 10/1/00

GLHP report includes claims denied 3rd, 4th, 5th and 6th time, total of 2,169 claims reported as being denied twice

CAPE only reported claims rejected for a second time with a DOS after 10/1/00

Wellness total number of claims is estimated

Care Choices reported combined 1st and 2nd quarter denied Medicaid claims

Community Choice number of claims are estimated

UPHP reporting claim lines, number is estimated

Total only reporting those claims it has responsibility to pay

NR-Information not reported NA-Not available, NP-Summary Information Not Provided